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24/41/80518

Reply

To the Editors:

We appreciate the thoughtful and well-researched letter from Dr. Murphy. His reply is consistent with the outlook of most interventional radiologists as they report their experiences.

A major point made by our report is that the format used by interventional radiologists is inconsistent with vascular surgical reporting standards. Dr. Murphy demonstrates the differing practices very well in his letter. For example, disputing the fact of an embolized stent as a complication is a clear deviation from vascular practice. Also, deployment of an additional $600 to $900 stent in the management of hemodynamically significant iatrogenic dissections remote from or adjacent to the target lesion cannot be compared with placement of an additional suture in an anastomosis. In a recently presented update of our iliac stent experience,[1] we found the relative risk of a complication to be increased when multiple stents are used (relative risk, 2.65; $p = 0.05$) during the procedure. Furthermore, the relative risk of subsequent iliac artery thrombosis was heavily influenced by the incidence of a procedure-related complication (relative risk, 15.33; $p < 0.0001$).

Dr. Murphy correctly makes the point that surgical intervention is more morbid than percutaneous angioplasty. We have no disagreement with this fact and instead make a plea for uniform reporting of complications. As interventionalists and vascular surgeons work increasingly close together, it is crucial that they speak a common language. Surgeons are trained to be meticulous in reporting complications and in discussing them openly. Successful management of an untoward event as described by Dr. Murphy is a tribute to the skill of the interventional radiologist but does not erase the fact of the complication. Lastly, although our experience demonstrates that outpatient iliac artery stent deployment can be done, that has not decreased our appreciation for the potential problems that can occur with the procedure.

As Dr. Murphy's letter provides strong evidence for the main point made in our article, we are grateful to him for taking the time to respond.

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REFERENCE

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24/41/80519

Regarding "Upper dorsal thoracoscopic sympathectomy for palmar hyperhidrosis: Improved intermediate-term results"

To the Editors:

Since 1990 we have performed more than 200 thoracoscopic sympathectomy procedures (in 100 patients) for palmar-axillary hyperhidrosis or Raynaud's phenomenon.

Contrary to the technique of Kopelman et al. (1996; 24:194-9), we have always used double-lumen intubation for ipsilateral lung collapse. Single-lumen intubation and CO_2 insufflation entails the risk of tension pneumothorax and dramatic hemodynamic changes as a result of elevated intrathoracic pressures and is to be avoided, in our opinion.

We have never seen postoperative atelectasis because we always ask the anesthesiologist to manually ventilate with positive end-expiratory pressure at the moment of instrument withdrawal. Only in one patient with bullous emphysema was postoperative thoracic drainage required, and all procedures were performed as planned.

We operate with the patient in a semisupine position, both sides consecutively, through two stab-wound incisions anterior on the chest in the second intercostal space. We are surprised by the high rate of complications (Horner's syndrome, brachialgia) described by Dr. Kopelman et al., which we think are a result of their surgical technique. We have always performed transpleural coagulation of T2-T3-T4 ganglia, avoiding any dissection of or traction on the sympathetic chain. Performing this technique, we have